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MEDICAID MEMO

TO: All Providers of Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFSDD) and Day Support (DS) Waiver Services in Virginia Medicaid

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 9/1/2016

SUBJECT: Service Authorization for the Developmental Disabilities (DD) Waivers and the New Waiver Management System (WaMS): Intellectual Disability Online System (IDOLS) Replacement

This memorandum provides information about the new WaMS system and service authorization process that will be used beginning September 1, 2016 as well as the transition of current authorizations into WaMS and VAMMIS.

Waiver Management System

The new WaMS is being developed by a contractor of the Virginia Department of Behavioral Health and Developmental Services (DBHDS), FEi Systems, a national company from Columbia, Maryland. Included in the redesign work is the development of a new web hosted waiver management system to replace IDOLS for entering the new DD Waivers service authorizations as well as the current process for DD Waiver service authorizations. All three redesigned waivers for persons with DD – the Community Living, the Family and Individual Supports, and the Building Independence – will utilize WaMS for service authorization, slot allocation, and wait list management. This system will be available for initial and modified service authorization requests effective 9/1/2016.

Service Authorization

FEi Systems is customizing the new WaMS to allow a single process for service authorizations for all three redesigned waivers for people with DD.

For all individuals who have had a SIS® completed, the level of support and accompanying reimbursement tier, as applicable, have been loaded into WaMS. Individuals' tiers have been entered into VAMMIS so that providers of services with tiered reimbursements will be able to be reimbursed at the appropriate tier.

With the implementation of the new DD waivers on 9/1/16, support coordinators and providers will utilize WaMS to request authorization for any of the following new and current services:

Assistive Technology	Center-Based Crisis Supports	Community-Based Crisis Supports
Community Engagement	Companion Services (CD & Agency)	Crisis Support Services
Electronic Home-Based Supports	Environmental Modifications	Group Day Services
Group Home Residential	Group Supported Employment	Independent Living Supports
Individual and Caregiver Training	Individual Supported Employment	In-Home Support Services
Personal Emergency Response (PERS)	Personal Assistance (CD & Agency)	Private Duty Nursing
Respite (CD & Agency)	Shared Living	Skilled Nursing
Sponsored Residential	Supported Living	Therapeutic Consultation
Transition Services	Workplace Assistance Services	

Migration

During preparation for "go-live" of WaMS, IDOLS will be unable to receive any service authorization requests in order to migrate the current information in the system to WaMS. Providers and CSBs must hold any requests during this time and submit them through WaMS on or after 9/1/16. Providers and CSBs will be given until 10/31/16 to update those service authorizations impacted by this migration. During this transition, requested service authorizations with complete information may be retroactively authorized back to the beginning of the migration period.

Service Specific Service Authorization Actions for Existing Services

Residential Services: *(Please see Medicaid Memo dated 5/31/16 for additional information related to these services)*

For **Group Home Residential,** which will be reimbursed according to the size of the group home and an individual's tier, the licensed bed capacity of every group home must be entered

into WaMS by the group home provider for each individual residing in that home. Each provider of group home services will need to initiate a service authorization request with the individual's support coordinator in order to facilitate accurate reimbursement by DMAS.

In preparation for WaMS initiation and the conversion of new procedures codes for group home services, DMAS will automatically close all current authorizations for congregate residential services on 8/31/16. New authorization lines will be added for the new procedures code with a start date of 9/1/16 and end date of 10/31/16. The authorization will not have a modifier reflecting the size of the home. This will enable providers to submit claims with the new procedure code and the provider will need to also add the proper modifier that reflects the licensed capacity of the home. Without the proper modifier reflected in the claim, it will be rejected. Providers will need to follow the steps above before 10/31/16 in order to receive the proper authorization that reflects the new procedure nodes and modifiers for each individual. Providers will also notice that the new authorizations will reflect 344 units per year versus units being reflected as units per month.

Providers of In-home Supports who have current authorizations in place for individuals, will continue to support those individuals on a 1:1 basis. Those that wish to deliver services and bill for two or three individuals simultaneously must submit a service authorization request to the support coordinator for submission through WaMS for each individual with the appropriate procedure code and modifier to indicate the number of individuals for whom the provider will be billing simultaneously.

Day/Employment Services: *(Please see Medicaid Memo dated 6/22/16 for additional information related to these services)*

Individuals authorized for **Day Support services** will remain authorized for that service and providers will continue to bill according to the current "block" unit structure until such time as the provider submits service authorization requests to move the individual to **Group Day Services** (or another service), which is billed in hourly units. Providers may opt to do this at one time for all individuals they support or as individuals' annual ISPs are updated. All authorizations must be converted to the new group day service no later than the end of the individual's current ISP.

Group Supported Employment will be reimbursed in hourly units according to the number of individuals in the group at the initiation of the amended waivers, instead of the current "block" unit structure. Group size is determined by the number of people supported in the group when it is full (vacancies do not change the group size) irrespective of the funding streams for the group members (i.e., waiver or non-waiver). Current authorizations will be ended effective 8/31/16 and new authorization lines created beginning 9/1/16 with the GSE procedure code and U3 modifier. This will enable providers to bill until such time that they correct the authorization to reflect the appropriate size of the group.

Prior to billing for GSE after 9/1/16, all providers of this service must relay to Heather Norton, at the DBHDS, via encrypted email to heather.norton@dbhds.virginia.gov or 804-786-5850, the

size of their group(s), the names and Medicaid numbers of the individuals supported in each group. This information will then be entered into WaMS by DBHDS. As with any authorization a new authorization notification will be generated once information has been updated in VAMMIS.

Medical/Behavioral Services: *(Please see Medicaid Memo dated 6/28/16 for additional information related to these services)*

Providers of Therapeutic Consultation must submit a new service authorization request through the support coordinator for submission through WaMS in order to bill at the new rates specific to the type of consultation provided.

Providers authorized for Skilled Nursing will have current authorizations terminated effective 8/31/16 and new authorizations for the skilled nursing procedure codes with the start and end dates consistent with the previous authorization. Providers must continue to evaluate the individual's support needs against the definition of this service and the definition of Private Duty Nursing. Some individuals will no longer qualify for Skilled Nursing, but should be considered for Private Duty Nursing instead. If the provider determines that this is the most appropriate service, then an authorization request would be made in WaMS.

The Medicaid Memo dated June 28, 2016 discussed the new **Private Duty Nursing (PDN)** service available to individuals in the redesigned waivers, the rates for existing Skilled Nursing and new Private Duty Nursing and billing codes, especially changes to billing codes for Skilled Nursing. The table below assists providers in adjusting to the billing code changes. Service authorization changes will be made to coincide with the procedure code changes. As indicated in the June 28 memo, individuals receiving skilled nursing may be assessed to determine whether private duty nursing is now the appropriate service.

	Before September 1, 2016	Eff. September 1, 2016
Skilled Nursing	T1002 (RN)/T1003 (LPN)	S9123 (RN)/S9124 (LPN)
PDN (new)	NA	T1002 (RN)/T1003 (LPN)

Additional hours may be authorized for certain services when used for supports delivered due to unpredictable events, such as illness of the individual, inclement weather, closing of a regularly scheduled day activity, behavioral intervention, loss of employment, loss of transportation. The Plan for Supports must define a specific support activity that will occur during those times when additional hours are billed. These additional hours may only be authorized for Sponsored Residential until 1/1/17. The support coordinator must request these hours via a note in WaMS to the Service Authorization Consultant with the appropriate justification for these hours.

As it relates to the waiver redesign, there will be no need for any modification of current service authorizations for the following existing waiver services:

Assistive Technology	Companion (agency or consumer-directed)	Environmental Modifications
Individual and Family/Caregiver Training	Individual Supported Employment	PERS
Personal Assistance (agency or consumer-directed)	Respite (agency or consumer-directed)	Services Facilitation
Sponsored Residential*	Transition Services	

* Changes to this service which will take effect 1/1/2017, inclusive of any required service authorization actions, will be discussed in a future Medicaid Memo.

Rounding Rules

During the preparation and transition to the new waivers, there have been many questions about the rules related to rounding units for the purposes of billing. These rules have not changed and can be referenced in the Elderly or Disabled with Consumer Directed Services manual, Chapter 5, page 12. This language noted below will be included in the new provider manual for the DD Waivers.

> "Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS."

General Information Training for Current Providers:

Private providers will have access to a pre-recorded customized webinar on WaMS that includes instructions for how to access the system and request service authorizations. This training webinar will is currently available on-line at http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign.

ADDITIONAL INFORMATION ON THE MEDICAID WAIVERS REDESIGN:

Virginia's Home and Community Based Services (HCBS) Developmental Disabilities Waivers are being redesigned to better assure that people with disabilities have the supports needed to design and achieve lives of quality and meaning in their communities. Updates on the waiver redesign can be found on the DBHDS website under *My Life, My Community* by going to: www.dbhds.virginia.gov. For questions, call toll-free 1-844-603-9248 (1-844-603-WAIV).

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a managed care program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Service Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Many Medicaid individuals are enrolled in one of the Department's managed care programs (Medallion 3.0, CCC and PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.